ork Presbyterian Hospital /Department of Interventional Radiology

Procedure Request Form

Patient Information

Patient Name (Last, First MI): D.O.B____/____/____

MRN: Date of intended procedure :

Pt. Tele. #: Status: ▫ outpatient ▫ inpatient
location:_____

For outpatients only (location): ▫**Milstein** ▫**51 Street**
Insurance Carrier: Member Name:_____ Policy Number:
Health Plan # Group #:

Exam Information

Attending Name: Phone/pager:

House staff Name: : Phone/pager:

Procedure Requested:

ICD-9 Code(s) Indication:

Indication for exam / treatment:

Is patient able to consent? ___YES ___NO If NO, provide name and phone number of Health Care Proxy:

Is patient ventilator dependant? ___YES ___NO Allergies? ___YES ___NO

Is the patient NPO? _____

Is patient on anticoagulation therapy? _____YES_____NO _____Type: _____

Labs within 30 days old: **CBC, basic metabolic panel, PT/PTT/INR**
Labs are ▫ in Webcis ▫ attached

Labs: WBC: BUN/CR:
H/H: PT/PTT:
PLAT: INR:

Instructions: Fax completed form and labs and a scheduler will call you to confirm appointment.
Inpatient Fax: (212) 305-5865 **Outpatient Fax: (212) 326-8824**

VIR Office Use Only

APPROVED BY:

DM	SC	PS	VS	DS	JS	JW	AV

PATIENT TRACKING:

DATE	COMMENTS:	INITIALS

Milstein Interventional Radiology – (212) 305-5123
51 Street Endovascular Radiology – (212) 326-8874